Consensus criteria for traumatic grief

A preliminary empirical test

H. G. PRIGERSON, M. K. SHEAR, S. C. JACOBS, C. F. REYNOLDS III, P. K. MACIEJEWSKI, J. R. T. DAVIDSON, R. ROSENHECK, P. A. PILKONIS, C. B. WORTMAN, J. B. W. WILLIAMS, T. A. WIDIGER, E. FRANK, D. J. KUPFER and S. ZISOOK

Background Studies suggest that symptoms of traumatic grief constitute a distinct syndrome worthy of diagnosis.

Aims A consensus conference aimed to develop and test a criteria set for traumatic grief.

Method The expert panel proposed consensus criteria for traumatic grief. Receiver operator characteristic (ROC) analyses tested the performance of the proposed criteria on 306 widowed respondents at seven months post-loss.

Results ROC analyses indicated that three of four separation distress symptoms (e.g. yearning, searching, loneliness) had to be endorsed as at least 'sometimes true' and four of the final eight traumatic distress symptoms (e.g. numbness, disbelief, distrust, anger, sense of futility about the future) had to be endorsed as at least 'mostly true' to yield a sensitivity of 0.93 and a specificity of 0.93 for a diagnosis of traumatic grief.

Conclusions Preliminary analyses suggest the consensus criteria for traumatic grief have satisfactory operating characteristics, and point to directions for further refinement of the criteria set.

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Recent studies using independent bereavement samples demonstrate that the symptoms of traumatic grief: (a) form a factor that is distinct from symptoms of depression and anxiety (Bierhals *et al*, 1996; Prigerson *et al*, 1995*a*,*b*, 1996*a*,*b*); (b) have distinct clinical correlates from those associated with depression (Beery *et al*, 1997; McDermott *et al*, 1997; van Doorn *et al*, 1999); and (c) predict numerous mental and physical health impairments, controlling for depressive symptoms (Prigerson *et al*, 1995*b*; 1996*b*, 1997*b*). Thus, an argument can be made that traumatic grief constitutes a syndrome that is distinct from other disorders and that is worthy of diagnosis. A panel of leading experts in reactions to loss and trauma, and in the formulation of psychiatric diagnostic criteria, convened for the purpose of formulating a criteria set for traumatic grief. This report presents an empirical test of the consensus criteria proposed by the expert panel.

NEED FOR STANDARDISED DIAGNOSTIC CRITERIA FOR A DISORDER OF GRIEF

According to the DSM–IV (American Psychiatric Association, 1994), depressive symptoms represent the only treatment-worthy complication of bereavement. These guidelines negate substantial and mounting evidence that symptoms apart from those of depression – symptoms of traumatic grief – may constitute a distinct psychiatric syndrome. The results of several recent studies of independent bereavement samples demonstrate that the symptoms of traumatic grief form a factor that is separate from symptoms of depression and anxiety (Prigerson *et al* 1995*a*,*b*, 1996*a*,*b*; Bierhals *et al*, 1996). Traumatic grief symptoms have been shown to have distinct clinical correlates from those associated with depression (e.g. distinctive electroencephalogram sleep architecture, McDermott *et al* 1997; distinctive relationships to the deceased, van Doorn *et al*, 1998), to persist over time among a significant minority (Pasternak *et al*, 1991; Prigerson *et al*, 1995*a*, 1997*a*,*b*), and to predict a variety of mental and physical health problems (e.g. suicidality, heart attacks), adjusting for depressive symptoms (Prigerson *et al*, 1995*b*, 1996*b*, 1997*a*). Taken together, these results suggest that traumatic grief constitutes a syndrome distinct from other disorders, and one warranting diagnosis and treatment.

Although we formerly referred to the disorder as 'complicated grief', we prefer 'traumatic grief' for several reasons. Similar to Horowitz *et al* (1997) we acknowledge the reaction to be a stress response syndrome and note that, as such, many of its symptoms resemble those of post-traumatic stress disorder (PTSD; e.g. disbelief, anger, shock, avoidance, numbness, a sense of futility about the future, a fragmented sense of security, trust, control). The trauma to which we refer represents a specific type of trauma – what appears to be a 'separation trauma'. Accordingly, in several studies we find that the symptoms of traumatic distress just noted load on a unidimensional factor with symptoms of separation distress (Prigerson *et al* 1995*a*,*b*; 1996*a*). The symptoms of separation distress include a preoccupation with thoughts of the deceased, longing and searching for the deceased and excessive loneliness following the loss. Consequently, we consider the term traumatic grief to accurately capture the phenomenology of the disorder because it refers to the two core components of the syndrome – symptoms of both 'separation distress' and 'traumatic distress'.

Most of the symptoms of pathological mourning we propose have been described by bereavement scholars from Freud (1917), to Anderson (1949), Parkes (1986), Middleton *et al* (1996) and Horwitz *et al* (1997). The symptoms independently observed by these diverse psychiatric researchers suggest that there is general agreement about the type of symptoms that would comprise a disorder of grief. Despite the general agreement about the type of symptoms that would denote a pathological grief reaction, explicit and consensually agreed upon diagnostic criteria for pathological grief have neither been formulated nor tested. Standardised diagnostic criteria for traumatic grief would assist clinicians in the accurate detection and treatment of individuals with this disorder. From a

research perspective, uniform, validated diagnostic criteria would facilitate studies of the prevalence, risk factors, outcomes, neurobiology and prevention of traumatic grief.

METHOD

In response to the need for standardised diagnostic criteria the authors of this paper and individuals interested in reactions to loss and trauma and/or in the formulation of diagnostic criteria for psychiatric disorders convened to develop preliminary criteria for traumatic grief. In this report, we describe a three-step procedure for the refinement of diagnostic criteria for traumatic grief. The first step involved a consensus conference to formulate an initial criteria set for traumatic grief, the second step involved an empirical test of the proposed criteria, and the third step pointed to directions for further refinement of the criteria based on the results of the preliminary test.

Development of consensus criteria

After a review of the available evidence that has emerged about traumatic grief, the panel agreed that elevated levels of grief symptomatology pose significant risks for mental and physical morbidity and adverse health behaviours. At the same time, the panel acknowledged that a wide range of 'symptoms' that occur after a loss could be considered within normal limits. The question, then, was how best to define the boundary between normal and pathological. After considerable discussion, the panel agreed that certain marked symptoms of grief, persisting for more than two months, should be the critical factor for distinguishing between normal and pathological grief.

The rationale for the two-month duration criterion was as follows. Data from two separate samples demonstrated that a six-month assessment was superior to two or three months post-loss assessments of traumatic grief for the prediction of adverse mental and physical health outcomes (Prigerson *et al*, 1995*b*, 1996*b*, 1997*a*). These results suggested that a six-month assessment of traumatic grief had good predictive validity. In addition, several members of the panel were concerned that heightened symptoms of traumatic grief prior to six months might encroach on the range of a normal bereavement response. However, some panel members felt that it would be inhumane to insist that bereaved individuals suffer for half a year, and preferred to follow the DSM–IV rule for major depressive disorder which stipulates two months post-loss as the point after which a diagnosis could be made. These individuals believed that benefits derived from early intervention would more than offset the costs of treating a subset of those individuals whose symptoms might resolve naturally. By focusing on a duration of at least two months rather than on the amount of time that had elapsed since the loss, confusion over the diagnosis of delayed reactions would be minimised (a diagnosis could be any time after the loss as long as the symptomatic distress endured at least two months), and those with extreme levels of distress early on could be diagnosed (and, presumably, treated) without delay. For these reasons the panel decided to propose at least two months' duration for the chosen symptoms (criterion C), but recognised that empirical work would ultimately determine when after the death, and how long the symptoms should endure, for a diagnosis of traumatic grief.

The panel then addressed the question of how to define the triggering event for traumatic grief. We discussed how a wide variety of losses might trigger a traumatic grief reaction, and wondered whether losses other than a death should be included. Ultimately, we decided to limit the type of loss to a death, and to define the criterion for loss as any death of a significant other (see criterion A1). We reasoned that once criteria for traumatic grief in response to the death of a significant other have been formulated and tested, it would be possible to test the criteria on those grieving over other losses (e.g. terminal illness, divorce).

The next task involved specifying the symptomatic criteria for traumatic grief. The panel decided that there were two basic symptom clusters that define traumatic grief – symptoms of separation distress and symptoms of traumatic distress (see Table 1).

Separation distress

The group agreed that symptoms of separation distress were at the core of this grief-related disorder. In addition to having experienced the death of a significant other (criterion A1), criterion A2 requires that the 'response involves intrusive, distressing preoccupation with the deceased person (e.g. yearning, longing, or searching)'. Although loneliness was not explicitly mentioned among the proposed criteria, we have found loneliness to be closely associated with impairments in social functioning and physical health (e.g. Prigerson *et al*, 1995*a*). For these reasons we added a loneliness item, and considered it to fit best as a manifestation of separation distress.

Traumatic distress

The panel decided to incorporate the symptoms of being traumatised by loss into a single cluster (criterion B). These symptoms were intended to represent bereavement-specific manifestations of being traumatised by the death. The proposed traumatic distress symptoms included efforts to avoid reminders of the deceased, feelings of purposelessness and futility about the future, a sense of numbness or detachment resulting from the loss, feeling shocked, stunned or dazed by the loss, difficulty acknowledging the death, feeling that life was empty and unfulfilling without the deceased, a fragmented sense of trust, security and control, and anger over the death. The facsimile illness symptom (i.e. experiencing symptoms or pain similar to that experienced by the deceased prior to his/her death) was considered another aspect of being traumatised by the loss. This specific criterion B item includes both symptoms of facsimile illness and the assumption of harmful behaviours of, or related to, the deceased. A new symptom based on feeling that a part of oneself had died, was added to the traumatic distress cluster to capture the identification with the deceased, as well as the sense of dismemberment precipitated by the loss. Taken together, the items of criterion B were intended to reflect the specific ways in which individuals with traumatic grief have been traumatised, or devastated, by their loss.

Preliminary test of the consensus criteria for traumatic grief

Sample

Analyses were conducted on data collected from S.Z. and Stephen Shuchter's San Diego widowhood study. This project recruited all newly bereaved widows and widowers in San Diego County who could be identified by death certificates filed at the San Diego County Department of Health Services. While a complete description of the study group is available elsewhere (Zisook & Shuchter, 1991), we provide a brief description of the recruitment and composition of the study group.

Widows and widowers (n=2466) were mailed a description of the study 2–3 weeks after the death of their partner and were invited to volunteer to participate by returning a postcard indicating their willingness for a home interview. Of the 2466 postcards, 1028 (42%) were returned. Of the 1028 individuals who responded 435 (42%) said they were, or might be, interested. All of these individuals were telephoned and 350 (80%) agreed to participate. Seven weeks after the death of their spouses, these subjects were interviewed in their own homes. No demographic data were available for the non-participants, making it difficult to compare respondents with non-respondents.

Of the 350 widows and widowers who entered the study, 308 (88%) completed the seven-month follow-up questionnaires. There were no differences in demographic factors, percentage of respondents meeting DSM–III–R (American Psychiatric Association, 1987) criteria for major depressive disorder, or mean levels of the traumatic grief symptoms, at the baseline assessment between those who did or did not complete follow-up questionnaires. The reasons provided for not completing the questionnaire were feeling too busy (n=5, 6%), and finding questions about the loss too painful (n=3, 5%).

Subjects had a mean age of 61 years (s.d.=10.4), 70% were female, and 95% were Caucasian. The mean number of years of schooling was 14.2 (s.d.=2.6). Subjects had been married an average of 32 years (s.d.=14.2). Of the 308 subjects, 43 (14%) had experienced a prior depressive episode, and 72 of 308 (23%) met DSM–III–R (1987) criteria for major depressive disorder at seven months.

Nearly all of the symptoms of the consensus criteria for traumatic grief could be found in the Widowhood Questionnaire (Zisook *et al*, 1987) which included questions assessing grief-specific feeling states, coping strategies, attachment behaviours, maintenance of old relationships and self-concepts.

Analyses

A series of ROC analyses were conducted to determine the operating characteristics for each item of the proposed criteria found in the Widowhood Questionnaire. Although the wording of the items in the Widowhood Questionnaire did not match exactly that of the proposed criteria, items which captured the basic nature of each criterion could be identified for all but the 'stunned, dazed and shocked' item. Respondents were asked to determine the extent to which each statement was true for them (0=completely false to 4=completely true) at the time the questionnaire was completed (seven months post-loss).

Items were examined to evaluate their ability to correctly identify subjects who did and did not meet criteria for traumatic grief. The criterion for a 'true case' was a score in the upper quintile of the distribution of the summed score of all the proposed criteria, minus the missing 'stunned' item. Determining 'caseness' in the absence of a diagnostic 'gold standard' represented a major challenge. As Kraemer (1992) has noted, a 'gold standard' is one that is "considered one of the best diagnostic procedures known to date of this disorder". In contrast with Horowitz *et al* (1997) who use a median-split, we chose the top 20% of the distribution of traumatic grief scores because this threshold has repeatedly been shown to be the best threshold for distinguishing individuals at risk for functional impairments (e.g. Prigerson *et al*, 1995*a*,*b*, 1997*a*). The upper 20% criterion is, in our estimation, one of the best empirically validated bases for determining 'caseness'. Furthermore, Horowitz *et al* (1997) found clinician's global ratings of the presence or absence of 'pathological grief' to have comparable sensitivity and specificity to a median-split using a grief symptom inventory, which suggests findings derived from use of a cut-off score may be comparable to those that use a clinician's evaluation.

A high priority was put on correctly identifying those who met criteria for traumatic grief (i.e. sensitivity). However, there was also concern for specificity because of the interest in distinguishing between normal and pathological grief reactions. These considerations guided the selection of the 'best thresholds' presented in Tables 1 and 2. The 'best threshold' was the level at which sensitivity was optimised with some consideration given to levels of specificity. So, for example, a sensitivity of 0.93 with specificity of 0.80 would be considered a better threshold than a sensitivity of 1.00 with a specificity of 0.17.

RESULTS

Using the upper 20% criterion for 'caseness', each of the proposed separation distress items – preoccupation with thoughts of the deceased, yearning and searching – had sensitivities and specificities in the range 0.63–0.80 (Table 1). We then determined the optimal symptom number and threshold for a diagnosis of traumatic grief based on the separation distress criteria (criterion A2) evaluated as a whole. Results indicated that if a respondent endorsed three of these four separation distress symptoms as being at least 'sometimes true', then the sensitivity would be 0.83 and the specificity would be 0.80. Although the yearning item had the highest sensitivity among the proposed criteria, when the loneliness item was included, loneliness had the highest sensitivity (0.93). Yearning also had the highest specificity (0.80) for analyses with and without inclusion of the loneliness item.

For the criterion B traumatic distress items, a sense of numbness, feelings of mistrust, and irritability had sensitivities of 0.90 or higher, but among the lowest specificities. Overall, the sensitivities for this cluster were above 0.73 for all but the 'difficulty imagining a fulfilling life without the deceased' and the 'feeling that a part of oneself has died' items. There were several indications that the former item was weak. Aside from low sensitivity, it had low specificity, and additional analyses revealed its item-total correlation to be 0.11. Furthermore, the internal consistency obtained for the entire set of items improved with the deletion of this item. For these reasons, we deleted the 'difficulty imagining life without the deceased' item. Similarly, we found the PTSD symptom of avoidance not only had low specificity, but its item-total correlation was extremely low (r=0.01), and Cronbach's alpha improved with the deletion of this item. Consequently, we deleted the avoidance item. Although the 'feeling that a part of oneself had died' item had the lowest sensitivity, it had the highest specificity, so this item was retained.

Refinement of consensus criteria

We then reran the analyses omitting the two poorly performing criterion B items, and found that the internal consistency of the entire criteria set improved (from Cronbach's alpha=0.77 to 0.81). Among this more parsimonious set of items, we found that if a respondent endorsed four of the remaining eight criterion B items as being 'mostly true', the sensitivity would be 0.89 and the specificity would be 0.81. The reanalyses of the criterion A2 items using the revised threshold score for caseness (i.e. upper 20% of

Table 1 Consensus criteria proposed for traumatic grief (n=306 widowed subjects at seven months post-loss)

	Best threshold[2]	Sensitivity	Specificity
Criterion A			
1. Person has experienced the death of a significant other	N/A	N/A	N/A
2. Response involves distressing, *intrusive preoccupation* with the deceased person (e.g. *yearning*, longing, or *searching* for the deceased)[1]	2	0.69	0.77
	2	0.71	0.80
	3	0.63	0.66
Criterion B – In response to the death, the following symptoms are marked and persistent:			
1. Frequent efforts to avoid reminders of the deceased (e.g. thoughts, feelings, activities, people, places)	3	0.75	0.49
2. Purposelessness or feelings of futility about the future	2	0.86	0.55
3. Subjective sense of numbness, detachment, or absence of emotional responsiveness	3	0.95	0.31
4. Feeling stunned, dazed, or shocked	N/A	N/A	N/A
5. Difficulty acknowledging the death (e.g. disbelief)	3	0.73	0.69
6. Feeling that life is empty or meaningless	3	0.73	0.80
7. Difficulty imagining a fulfilling life without the deceased	3	0.58	0.65
8. Feeling that part of oneself has died	2	0.49	0.92
9. Shattered world view (e.g. lost sense of security, *trust*, control)	3	0.90	0.31
10. Assumes *symptoms* or harmful behaviours *of*, or related to, *deceased* person	3	0.78	0.49
11. Excessive *irritability*, bitterness, or anger related to the death	3	0.90	0.49
Criterion C			
Duration of disturbance (symptoms listed) is at least two months	N/A	N/A	N/A
Criterion D			
The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning[3]	N/A	N/A	N/A

1. Sensitivity and specificity refer to the italicised term.
2. 'Best threshold' refers to level that provided the optimal balance of sensitivity and specificity. Coding was: 0=completely false; 1=mostly false; 2=true and false; 3=mostly true; 4=completely true. N/A, indicates no available data for this item.
3. No data were available in the present analyses, but several studies show that these symptoms predict functional impairment (e.g. Prigerson *et al*, 1995*a*,*b*, 1997*a*,*b*).

the reduced set of items) revealed an improvement such that endorsing at least three of the four items as at least 'sometimes true' yielded an improved sensitivity of 0.93 and specificity of 0.81 for the criterion A2 items.

We then evaluated the diagnostic probabilities that would result from the combination of criteria A2 and B. The results indicated that endorsing three of the four criterion A items and four of the eight criterion B items would yield a sensitivity of 0.93 and specificity of 0.93. Thus, using both criteria conjointly, which is what would occur in clinical practice, would provide the highest rates of sensitivity and specificity. The refined criteria set based on these analyses can be found in Table 2.

DISCUSSION

Traumatic grief symptomatic criteria (criteria A and B)

This report presents the first consensually agreed upon criteria set for traumatic grief, provides a preliminary empirical test of the consensus criteria for traumatic grief, and suggests a potential refinement of the criteria based on the empirical results. The final results indicated that endorsing three of the four symptoms of separation distress (criterion A2) as at least sometimes true, and endorsing four of the eight traumatic distress symptoms (criterion B) as at least mostly true, provides a diagnosis for traumatic grief that has a high degree of sensitivity and specificity.

More specifically, with respect to the criterion A2 items, we found that as a group, and including 'loneliness', they had satisfactory operating characteristics. With respect to the criterion B items, we found that omitting the 'not fulfilled without the deceased' and the 'avoidance' items enhanced parsimony and improved both the internal consistency and diagnostic accuracy of this 'traumatic distress' set. Removal of the avoidance item would mark a departure from the criteria for 'complicated grief' proposed by Horowitz *et al* (1997), which posit avoidance as one of the two core criteria required for a diagnosis.

Further empirical validation required for the timing and functional impairment criteria (criteria C and D)

The criteria we propose also differ from the Horowitz *et al* (1997) specification that the diagnosis not be made prior to 14 months post-loss. The panel agreed, and preliminary analyses found in prior reports (e.g. Prigerson *et al*, 1995*b*, 1996*b*) and the results of this study suggest, that individuals with marked and persistent symptoms of traumatic grief are a distressed, 'at risk' group that can be identified much earlier. Nevertheless, we withhold comment on the validity of our duration criterion until we have tested the criterion C 'at least two months duration' explicitly. By contrast, recent studies (Prigerson *et al*, 1995*a*,*b*, 1997*a*) demonstrate that symptoms of

Table 2 Refined criteria for traumatic grief (n=306 widowed subjects at seven months post-loss)

	Best threshold[1]	Sensitivity	Specificity
Criterion A	Sometimes true	0.93	0.81
1. Person has experienced the death of a significant other			
2. Response involves 3 of the 4 symptoms below experienced at least sometimes:			
(a) Intrusive thoughts about the deceased			
(b) Yearning for deceased			
(c) Searching for the deceased			
(d) Loneliness as result of the death			
Criterion B – In response to the death, the 4 of the 8 following symptoms experienced as mostly true:	Mostly true	0.89	0.82
1. Purposelessness or feelings of futility about the future			
2. Subjective sense of numbness, detachment, or absence of emotional responsiveness			
3. Difficulty acknowledging the death (e.g. disbelief)			
4. Feeling that life is empty or meaningless			
5. Feeling that part of oneself has died			
6. Shattered world view (e.g. lost sense of security, *trust*, control)			
7. Assumes symptoms or harmful behaviours of, or related to, the deceased person			
8. Excessive irritability, bitterness, or anger related to the death			
Criterion C			
Duration of disturbance (symptoms listed) is at least two months	N/A	N/A	N/A
Criterion D			
The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning	N/A	N/A	N/A
Overall		0.93	0.93

1. Refers to the threshold level with the optimal balance of sensitivity and specificity. Two of the 308 subjects at the seven months post-loss assessment were excluded because of missing data.

traumatic grief do predict 'clinically significant impairment in social, occupational or other important areas of functioning' (criterion D). Nevertheless, further validation studies that examine temporal course, determine prevalence rates for traumatic grief at set times from the loss, and that compare the functional impairment and morbidity associated both with the proposed criteria and a variety of temporal trajectories (e.g. absent, early acute, delayed, chronic grief subtypes) will be required before more definitive conclusions can be drawn with respect to criteria C and D.

Distinguishing traumatic grief from normal grief

To a large extent, normal grief reactions can be characterised by the absence of the specified levels of the proposed criteria. For example, individuals who are able to acknowledge the death (not feel disbelief), who do not feel extremely lonely or empty after the loss, who are able to feel emotionally connected to others, that life still holds meaning and purpose, whose sense of self, personal efficacy and trust in others has not been shaken by the loss, and who are not angered over the loss, would appear to be adapting to life in the absence of the deceased. These survivors would be expected to feel sad about the loss and miss the deceased, particularly in the first few months following the loss, but would experience a gradual return of the capacity for reinvestment in new interests, activities and relationships. They would also experience an attenuation of their distress (i.e. not have marked and persistent levels of traumatic grief symptoms) and generally appear capable of adjusting to their new circumstances.

Distinguishing traumatic grief from PTSD

In the case of traumatic grief, the trauma is typically a 'separation trauma' and, therefore, includes symptoms of separation distress (e.g. yearning, searching) not included among the DSM–IV criteria for PTSD. The results indicated that the PTSD 'avoidance' and 'hypervigilance' criteria play a much less central role in the diagnosis of traumatic grief than they do for PTSD. For traumatic grief, it is the absence of the deceased that is the source of the distress, rather than fears that the traumatic event will be re-experienced, and hypervigilance refers primarily to a searching for cues of the deceased. Thus, while traumatic grief symptoms overlap with many PTSD-like symptoms, there are important distinctions which set it apart from PTSD.

Future directions

Extensive field testing of the proposed criteria on representative samples of bereaved individuals will be required before standardised criteria can be proposed. Future studies will need to determine the optimal timing/duration criterion and to test for possible subtypes of traumatic grief. The syndrome we outline appears similar to that of chronic grief described by researchers such as Middleton *et al* (1996), but future studies may find support for subtypes such as 'delayed' or 'inhibited' grief. Studies will need to determine whether the symptomatic

presentation differs based on the survivor's age, kinship and connection to the deceased (e.g. parent, degree of closeness), and according to the traumatic circumstances of the death (e.g. suicide, homicide, accidents). Future work could also examine the extent to which this syndrome emerges after other types of losses (e.g. divorce). Following the lead of researchers such as Eisenbruch (1990), studies of traumatic grief begun in other countries (e.g. Pakistan, Norway, Egypt, Chile, Belgium) will inform us of the role of culture in reactions to bereavement. The proposal and preliminary testing of consensus criteria provide an initial step towards the international standardisation of diagnostic criteria for traumatic grief.

CLINICAL IMPLICATIONS

- Standardised diagnostic criteria for traumatic grief would promote the accurate detection and early treatment of individuals with this disorder.
- Precise definition of traumatic grief will lead to the development of more specific treatments.
- Standardised diagnostic criteria for traumatic grief would facilitate studies of the prevalence, risk factors, outcomes, neurobiology and prevention of this disorder.

LIMITATIONS

- The number who responded to the initial mailing was quite low and little information was available to indicate how participants and non-participants may have differed.
- Not all of the proposed consensus criteria were available in the data set on which the analyses were conducted.
- The criterion for 'caseness' of traumatic grief indicated the extent to which respondents were above or below the upper quintile of the distribution of the summary score for all the criteria, instead of a diagnosis determined by a 'gold standard'.

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HOLLY G. PRIGERSON, PhD, Yale University, New Haven, CT; M. KATHERINE SHEAR, MD, SELBY C. JACOBS, MD, CHARLES F. REYNOLDS, III, MD, PAUL K. MACIEJEWSKI, PhD, JONATHAN R. T. DAVIDSON, MD, ROBERT ROSENHECK, MD, PAUL A. PILKONIS, PhD, CAMILLE B. WORTMAN, PhD, JANET B. W. WILLIAMS, DSW, THOMAS A. WIDIGER, PhD, ELLEN FRANK, PhD, DAVID J. KUPFER, MD, SIDNEY ZISOOK, MD, Northeast Program Evaluation Center, Veterans Affairs Medical Center (182), Campbell Avenue, West Haven, CT 06516

Correspondence: Dr Prigerson, Room 144, Connecticut Mental Health Center, Yale University School of Medicine, 34 Park Street, New Haven, CT 06519, USA. E-mail: Holly.Prigerson@Yale.edu

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